UNITED STATES
NUCLEAR REGULATORY COMMISSION
REGION II
SAM NUNN ATLANTA FEDERAL CENTER
61 FORSYTH STREET, SW, SUITE 23T85
ATLANTA, GEORGIA 30303-8931

January 6, 2005

Mr. Rory J. O'Kane
Plant Manager
Honeywell Specialty Chemicals
P.O. Box 430
Metropolis, IL 62690

SUBJECT: NRC INSPECTION REPORT 40-3392/2004-011 AND NOTICE OF VIOLATION

Dear Mr. O'Kane:

This letter refers to the inspection conducted on December 6 through 10, 2004, at the Honeywell Specialty Chemicals facility. The purpose of the inspection was to perform a review of operations and management controls and organization, and observe and evaluate the annual emergency preparedness exercise, to determine whether activities authorized by the license were conducted in accordance with NRC requirements. At the conclusion of the inspection on December 10, 2004, the findings were discussed with those members of your staff identified in the enclosed report.

The inspection consisted of an examination of activities conducted under the license as they relate to safety and compliance with the Commission's rules and regulations and with the conditions of the license. Areas examined during the inspection are identified in the enclosed report. Within these areas, the inspection consisted of a selective examination of procedures and representative records, observations of activities in progress, and interviews with personnel.

Based on the results of this inspection, the NRC has determined that a Severity Level IV violation of NRC requirements occurred. The violation was evaluated in accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG 1600, which is included on the NRC's web site at http://www.nrc.gov/what-we-do/regulatory/enforcement.html. The violation is cited in the enclosed Notice of Violation (Notice), and the circumstances surrounding the violation are described in the subject inspection report. The violation involved the failure of operations personnel to properly perform pre-fill inspections of uranium hexafluoride cylinders.

You are required to respond to this letter and should follow the instructions specified in the enclosed Notice when preparing your response. The NRC will use your response, in part, to determine whether further enforcement action is necessary to ensure compliance with regulatory requirements.

In accordance with 10 CFR 2.390 of the NRC's "Rules of Practice," a copy of this letter, its enclosures, and your response will be made available electronically for public inspection in the NRC Public Document Room or from the NRC's document system (ADAMS), accessible from the NRC Web site at http://www.nrc.gov/reading-rm/adams.html. To the extent possible, your response should not include any personal privacy, proprietary, or safeguards information so that it can be made available to the Public without redaction.

Please note that on October 25, 2004, the NRC terminated public access to ADAMS and initiated an additional security review of publicly available documents to ensure that potentially sensitive information is removed from the ADAMS database accessible through the NRC's web site. Interested members of the public may obtain copies of the referenced documents for review and/or copying by contacting the Public Document Room pending resumption of public access to ADAMS. The NRC Public Documents Room is located at NRC Headquarters in Rockville, MD, and can be contacted at (800) 397-4209.

Should you have any questions concerning this letter, please contact us.

Sincerely,

/RA/

Jay L. Henson, Chief
Fuel Facility Inspection Branch 2
Division of Fuel Facility Inspection

Docket No. 40-3392
License No. SUB-526

Enclosures: 1. Notice of Violation
2. NRC Inspection Report 40-3392/2004-011

cc w/encls:
Gary Wright
Emergency Management Agency
Division of Nuclear Safety
1035 Outer Park Dr., 5th Floor
Springfield, IL 62704

Distribution w/encls: (See page 3)

Distribution w/encls:
J. Henson, RII
J. Lusher, NMSS
B. Nelson, NMSS
M. Raddatz, NMSS

PUBLIC DOCUMENT (circle one): YES NO

OFFICE	RII:DFFI	RII:DFFI	RII:DFFI		
SIGNATURE	OL 1/5/05	RG 1/5/05	DH 1/5/05		
NAME	O. Lopez	R. Gibson	D. Hartland		
DATE	01/ /05	01/ /05	01/ /05		
E-MAIL COPY?	YES NO	YES NO	YES NO	YES NO	YES NO

OFFICIAL RECORD COPY DOCUMENT NAME: E:\Filenet\ML050070041.wpd

NOTICE OF VIOLATION

Honeywell Specialty Chemicals
Metropolis, Illinois

Docket No. 40-3392
License No. SUB-526

During an NRC inspection conducted on December 6 through 10, 2004, a violation of NRC requirements was identified. In accordance with the "General Statement of Policy and Procedure for NRC Enforcement Actions," NUREG-1600, the violation is listed below.

> License Condition 10 of NRC License No. SUB-526, Amendment No. 15, authorizes, in part, the use of licensed materials in accordance with the statements, representations, and conditions in Chapters 1 through 7 of the license application dated January 30, 2003.
>
> Chapter 2, Section 2.6 of the license application, dated January 30, 2003, requires that "plant operations shall be conducted in accordance with written Standard Operating Procedure Manuals."
>
> Section 5.1.3 of Procedure MTW-SOP-DIS-0200, "Distillation Operation," Revision 4, requires that operators perform a pre-fill inspection of uranium hexafluoride (UF_6) cylinders and document results in the following prior to connecting a cylinder at a fill spot:
>
> - Attachment B Sign Off Page
> - UF_6 Cylinder Check Prior to Filling Checklist
> - UF_6 Cylinder Database
>
> The UF_6 Cylinder Check Prior to Filling Checklist and Database requires verification that a Hunt valve is not attached to the cylinder.
>
> Contrary to the above, on December 3, 2004, after a customer notified the licensee that it had received cylinders with Hunt valves attached, it was identified that operations were not conducted in accordance with written Standard Operating Procedure Manuals. Specifically, operators did not properly perform the UF_6 Cylinder Check Prior to Filling Checklist and Database which resulted in several cylinders equipped with Hunt valves to be connected at a fill spot and subsequently filled with liquid UF_6.

This is a Severity Level IV violation (Supplement VI).

Pursuant to the provisions of 10 CFR 2.201, Honeywell Speciality Chemicals is hereby required to submit a written statement or explanation to the U.S. Nuclear Regulatory Commission, ATTN: Document Control Desk, Washington, D.C. 20555 with a copy to the Regional Administrator, Region II, within 30 days of the date of the letter transmitting this Notice of Violation (Notice). This reply should be clearly marked as a "Reply to a Notice of Violation" and should include: (1) the reason for the violation, or, if contested, the basis for disputing the violation or severity level, (2) the corrective steps that have been taken and the results achieved, (3) the corrective steps that will be taken to avoid further violations, and (4) the date

when full compliance will be achieved. Your response may reference or include previous docketed correspondence, if the correspondence adequately addresses the required response. If an adequate reply is not received within the time specified in this Notice, an order or a Demand for Information may be issued as to why the license should not be modified, suspended, or revoked, or why such other action as may be proper should not be taken. Where good cause is shown, consideration will be given to extending the response time.

If you contest this enforcement action, you should also provide a copy of your response to the Director, Office of Enforcement, United States Nuclear Regulatory Commission, Washington, D.C. 20555-0001.

Because your response will be made publically available, to the extent possible, it should not include any personal privacy, proprietary, or safeguards information so that it can be made publically available without redaction. If personal privacy or proprietary information is necessary to provide an acceptable response, then please provide a bracketed copy of your response that identifies the information that should be protected and a redacted copy of your response that deletes such information. If you request withholding of such material, you must specifically identify the portions of your response that you seek to have withheld, and provide in detail the basis for your claim of withholding (e.g., explain why the disclosure of information will create an unwarranted invasion of personal privacy or provide the information required by 10 CFR 2.390(b) to support a request for withholding confidential commercial or financial information). If safeguard's information is necessary to provide an acceptable response, please provide the level of protection described in 10 CFR 73.21.

In accordance with 10 CFR 19.11, you may be required to post this Notice within two working days.

Dated this 6th day of January, 2005

U.S. NUCLEAR REGULATORY COMMISSION

REGION II

Docket No.:	40-3392
License No.:	SUB-526
Report No.:	40-3392/2004-011
Licensee:	Honeywell International, Inc.
Facility:	Metropolis Works
Location:	P. O. Box 430 Metropolis, IL 62960
Dates:	December 6 through 10, 2004
Inspectors:	David J. Hartland, Senior Fuel Facility Inspector Omar R. López, Fuel Facility Inspector Richard Gibson Jr., Health Physicist
Approved by:	Jay L. Henson, Chief Fuel Facility Inspection Branch 2 Division of Fuel Facility Inspection

Enclosure 2

EXECUTIVE SUMMARY

Honeywell International, Inc.
NRC Inspection Report 40-3392/2004-011

The purpose of this routine inspection was to observe and evaluate the licensee's plant operations, management organization and controls, and performance during the annual exercise of its Emergency Response Plan/Radiological Contingency Plan. The inspections involved observation of work activities, a review of selected records, and interviews with plant personnel. The inspection identified the following aspects of the program as outlined below:

Operational Safety Review

- Operators were attentive and cognizant of current process conditions. However, a violation was identified for failure to properly perform uranium hexafluoride cylinder pre-filling checks, allowing cylinders equipped with Hunt valves to be filled and ultimately shipped. (Paragraph 2.a)

- Procedures reviewed contained adequate operational and safety information. The inspectors verified that the licensee's procedures used to implement the management of change program were consistent with license requirements. (Paragraph 2.b)

Management Organization, and Controls

- Health, Safety, and Environment Council assessments were documented and conveyed to management, and findings were resolved in a timely manner. The licensee intended to develop a tracking system for findings and approve the draft policy and procedure for implementation. (Paragraph 3.a)

- The inspectors noted that the number and age of past due items in the corrective action system continued to trend upward. In addition, the inspectors noted that the system was being used as an action tracking tool rather than as a mechanism for assessing significance of items, prioritizing and initiating investigations, and performing adverse trend analyses. Licensee staff indicated that use of the system was evolving and intended to take action to address the issues. (Paragraph 3.b)

Emergency Preparedness

- The exercise objectives and scenario adequately exercised major elements of the Emergency Response Plan/Radiological Contingency Plan. However, several last-minute scenario changes resulted in some confusion between the controllers and players during the exercise. (Paragraph 4.a)

- The Incident Commander and other responding personnel performed in a manner that would have protected the workers' safety and resulted in timely mitigation of the UF_6 release. However, personnel were slow in responding to the injured worker and establishing a decontamination station. (Paragraph 4.b)

- The inspectors observed that the Crisis Manager (CM) took the proper actions delineated in the licensee's Emergency Plan. However, there was poor communication between the CM and Incident Commander regarding the downgrading of the Site Area Emergency, and the criteria for doing so was not clear. (Paragraph 4.c)

- The exercise critique was a candid assessment of the response and numerous items were identified by the licensee for program improvement, including those noted by the inspectors, and entered into their corrective action system. (Paragraph 4.d)

- The inspectors determined that, overall, the licensee's performance in responding to the release was a successful demonstration of an emergency response program maintained in a state of operational readiness, with personnel trained and familiar with procedures for implementing the Emergency Response Plan/Radiological Contingency Plan. (Paragraph 4.d)

Attachment:
Partial List of Persons Contacted
Inspection Procedures Used
Items Opened, Closed, and Discussed
List of Acronyms Used

REPORT DETAILS

1. Summary of Plant Status

During the inspection period, operations in the Feeds Material Building (FMB) were in a shutdown mode due to uranium hexafluoride (UF_6) blockage in several vacuum lines. Maintenance activities were ongoing during the week to clean the lines and restore the affected systems.

2. Operational Safety Review (Temporary Instruction 2600/003)

a. Observation of Plant Activities

(1) Scope and Observations

The inspectors observed ongoing maintenance activities involving the cleaning of UF_6 piping, including pre-job briefings for the related activities, and determined that they were conducted safely and in accordance with licensee procedures. The inspectors also reviewed the special work permit and noted that personal protective equipment to address potential hazards was specified. No safety issues were identified.

The inspectors observed activities in the FMB control room. The inspectors noted that log books were current and descriptive for activities conducted during the shift. During shift turnover, control room supervisors and operators conveyed relevant process conditions to on-coming personnel, who reviewed the log books prior to assuming duties. Operators were aware of the procedure reference manual location and contents.

The inspectors also toured the plant during backshift hours and observed that operators were attentive and cognizant of current process conditions. The areas toured included the FMB and the control rooms in the Effluent Process Facility and Power House. No issues were noted.

However, on December 7, while observing operations and maintenance personnel replace a valve on a UF_6 cylinder, the inspectors noted that, although it appeared that the steps were performed as required, the operator was not initialing the in-hand checklist as each step was completed. By failing to do so, the inspectors noted that the operator could have missed a step.

The licensee had recently identified that the improper completion of checklists had led to a violation of a commitment previously made to the NRC. The licensee was notified by customers who had recently received a total of fourteen cylinders that they were equipped with Hunt valves. In response to issues regarding these valves, the licensee had previously committed to the NRC that they would not ship cylinders owned by them with these valves.

During followup, the licensee identified that a checklist used by operators prior to filling cylinders contained a verification that a Hunt valve was not attached. However, the checklists were apparently completed without performing the required verification, due

to a lack of clarity in the checklists and unclear expectations regarding their completion. Seven other cylinders that had previously been filled and were ready for shipment from the site were discovered to have Hunt cylinder valves.

Section 5.1.3 of Procedure MTW-SOP-DIS-0200, "Distillation Operation," Revision 4, required that operators perform a pre-fill inspection of cylinders and document results in the following prior to connecting a cylinder at a fill spot:

- Attachment B Sign Off Page
- UF_6 Cylinder Check Prior to Filling Checklist
- UF_6 Cylinder Database

The UF_6 Cylinder Check Prior to Filling Checklist and Database required verification that a Hunt valve was not attached to the cylinder.

Contrary to the above, on December 3, 2004, the licensee identified that plant operations were not conducted in accordance with written Standard Operating Procedure Manuals. Specifically, operators did not properly perform the UF_6 Cylinder Check Prior to Filling Checklist and Database which resulted in several cylinders equipped with Hunt valves to be connected at a fill spot and subsequently filled with liquid UF_6. Failure to properly perform the UF_6 Cylinder Check Prior to Filling Checklist and Database was identified as Violation 04003392/2004011-01.

(2) Conclusions

Operators were attentive and cognizant of current process conditions. However, a violation was identified for failure to properly perform UF_6 cylinder pre-filling checks allowing cylinders equipped with Hunt valves to be filled and ultimately shipped.

b. Review of Operating Procedures

(1) Scope and Observations

The inspectors reviewed procedure manuals for the fluorination, green salt, and distillation processes to verify that appropriate operating procedures were being used. The procedure manuals contained information on plant startup, routine operations, and shutdown (emergency and normal). The procedure manuals also contained Materials Safety and Data Sheets and equipment lists.

The inspectors noted that the licensee had addressed an issue identified during a previous inspection regarding the lack of procedural guidance for handling under-filled cylinders at the lift platform. The applicable procedure was revised that required under-filled cylinders to be cooled prior to lifting to prevent them from swinging in an uncontrolled manner due to shifting of material inside the cylinder.

The inspectors also discussed with fluorination and distillation operators the procedures to be used for the existing operating conditions at the time of the shift change. The inspectors noted that operators were knowledgeable of the operating procedures. Also,

the inspectors reviewed the FMB control room alarm response procedures. No problems were identified.

The inspectors reviewed the licensee's management of change (MOC) program to verify compliance with the license. The inspectors reviewed the plant policy for process modifications, the MOC procedure, and the procedure for development and implementation of technical procedures. The inspectors noted those changes to operating procedures that were not administrative were subjected to the MOC process. The inspectors noted that inconsistencies between requirements in Section 13.4.9 of the license application and procedure requirements for implementing the management of change process that were identified in previous inspections had been addressed. No problems were identified.

(2) Conclusions

Procedures reviewed contained adequate operational and safety information. The inspectors verified that the licensee's procedures used to implement the management of change program were consistent with license requirements.

3. Management Organization and Controls (Inspection Procedure (IP) 88005)

a. Internal Reviews and Audits

(1) Scope and Observations

The inspectors reviewed the Health, Safety, and Environment Council Assessment Program to verify that audits and inspections were performed, the results documented and conveyed to management, and that audit findings were resolved in a timely manner. The inspectors reviewed recent assessments and noted that they were well documented and findings were resolved in a timely manner. The inspectors also accompanied licensee personnel during an assessment in the FMB and noted that the assessment was detailed and that quality findings were identified.

In addition, the inspectors noted that the licensee was using a draft policy and procedure for implementation of the Health, Safety, and Environment Council Assessment Program as they were still developing the program. Also, the licensee stated that they were developing a tracking system for findings identified during the assessments. The inspectors will continue to monitor the licensee's progress in implementing the new assessment program using existing Inspector Followup Item 04003392/2003-007-04, licensee actions to centralize and automate the corrective action system to enhance their ability to perform adverse trend analyses.

(2) Conclusions

Health, Safety, and Environment Council assessments were documented and conveyed to management, and findings were resolved in a timely manner. The licensee intended to develop a tracking system for findings and approve the draft policy and procedure for implementation.

b. Corrective Action Program

(1) Scope and Observations

The inspectors continued to assess the license's overall timeliness in resolving issues that were entered into their corrective action system ("e-CATS") and noted that the percentage of past due items continued to trend upward. Latest data, dated December 13, 2004, indicated that 77 percent of items were over due an average of 85 days. Licensee staff indicated that most of the past due items were awaiting approval or owner response and could be easily dispositioned.

The inspectors also reviewed new items recently inputted into the system and noted that they were primarily recommendations resulting from Triangle of Prevention investigations rather than events/near misses that initiated the investigations. The inspectors noted that, as a result, e-CATS appeared to be being used merely as an action tracking tool rather than as a mechanism for assessing significance of items, prioritizing and initiating investigations, and performing adverse trend analyses. Licensee staff indicated that the use of the system was still evolving and that they intended to eventually use it for those purposes.

The inspectors will continue to monitor the licensee's progress in implementing the new corrective action system using existing Inspector Followup Item 04003392/2003-007-04, licensee actions to centralize and automate the corrective action system to enhance their ability to perform adverse trend analyses.

(2) Conclusions

The inspectors noted that the number and age of past due items in the corrective action system continued to trend upward. In addition, the inspectors noted that the system was being used as an action tracking tool rather than as a mechanism for assessing significance of items, prioritizing and initiating investigations, and performing adverse trend analyses. Licensee staff indicated that use of the system was evolving and intended to take action to address the issues.

4. Emergency Preparedness (IP 88050)

a. Exercise Objectives and Scenario

(1) Scope and Observations

The inspectors reviewed the objectives and scenario for the licensee's December 8, 2004, annual graded emergency preparedness exercise and determined that they adequately challenged the various elements of the Emergency Response Plan/Radiological Contingency Plan. Although the scenario provided a challenging framework to demonstrate the licensee's capability to implement the response and contingency plans, the licensee had slightly changed the scenario to simulate some additional events just prior to the exercise, which caused some confusion between the controllers and the players during the exercise. In addition, the simulated wind direction

was opposite of the actual direction. Also, there were three simulated operations being conducted under normal plant conditions which, in reality, would not occur.

The scenario involved some misvalving errors by a lab technician while sampling UF_6 from the Kinney sampling system resulting in the release of UF_6 from the north side of the Feed Materials Building and beyond the fence line of the plant. A maintenance person who reported the leak to the lead foreperson inadvertently walked through the simulated plume and reported her injuries to the FMB control room in person. The inspectors noted that the 2004 scenario was suitably different from the scenario used during the previous graded exercise that occurred in 2002.

(2) Conclusions

The inspectors determined that the exercise objectives and scenario adequately exercised major elements of the Emergency Response Plan/Radiological Contingency Plan. However, several last-minute scenario changes resulted in some confusion between the controllers and players during the exercise.

b. Incident Command

(1) Scope and Observations

The inspectors assessed the licensee's recognition of abnormal plant conditions, command and control, communications, and overall implementation of the Emergency Response Plan/Radiological Contingency Plan and procedures. The inspectors observed that the incident command post was effectively established at the south end of the Feed Material Building, which was suitably upwind of the release. Response to the scene was by the Incident Commander (IC), the emergency response team, and onsite medical personnel.

The IC effectively communicated with the responders in the control room to ensure that a valve was closed to isolate the simulated leak of UF_6 from the Kinney sampling system. The two workers responsible for securing the release were adequately briefed prior to approaching the isolation valve to ensure a timely entry and exit. The inspectors noted that the responders properly identified the isolation valve, closed it, and exited the area in a safe manner.

Emergency facilities and equipment were adequate and operational. However, the inspectors noted that there was a slight delay by plant staff in establishing a decontamination station and attending to and decontaminating the injured worker. The emergency response team and medical personnel were able to remove the injured worker from the scene for medical help and surveys without incident.

(2) Conclusions

The inspectors determined that the IC and other responding personnel performed in a manner that would have protected the workers' safety and resulted in timely mitigation

of the UF_6 release. However, personnel were slow in responding to the injured worker and establishing a decontamination station.

c. Crisis Manager

(1) Scope and Observations

The inspectors observed that the Crisis Manager (CM) took the proper actions delineated in the licensee's Emergency Plan. These actions consisted of timely notification of offsite agencies including the state, local emergency services and disaster coordinator, and the NRC; informing those agencies of the time of the releases and meteorological conditions; providing status of the facility including release locations and event classification; and providing brief description of personnel injuries and property damages, and recommended protective actions. However, there was poor communication between the CM and IC regarding the downgrading of the Site Area Emergency, and the criteria for doing so was not clear.

(2) Conclusions

The inspectors observed that the Crisis Manager took the proper actions delineated in the licensee's Emergency Plan. However, there was poor communication between the CM and IC regarding the downgrading of the Site Area Emergency, and the criteria for doing so was not clear.

d. Critiques

(1) Inspection Scope and Observations

The licensee conducted a critique following the exercise which afforded players, controllers, and observers an opportunity to provide comments. The exercise critique was a candid assessment of the response and numerous items were identified by the licensee for program improvement, including those noted by the inspectors, and entered into e-CATS for tracking the completion of corrective actions.

(2) Conclusions

The exercise critique was a candid assessment of the response and numerous items were identified by the licensee for program improvement, including those noted by the inspectors, and entered into e-CATS for tracking the completion of corrective actions.

The inspectors determined that, overall, the licensee's performance in responding to the release was a successful demonstration of an emergency response program maintained in a state of operational readiness, with personnel trained and familiar with procedures for implementing the Emergency Response Plan/Radiological Contingency Plan.

5. Follow up on Previously Identified Issues

a. (Open) VIO 40-3392/2004-008-02: Two examples of conduct of operations that were not specifically addressed or described in detail in written Standard Operating Procedures. The first example was failure to have a procedure that described cross-tie configuration between fluorinator trains and the Nash pumps. The licensee had modified the applicable procedure to address this issue and developed a temporary procedure to provide guidance for shutting down the Nash pumps for reconfiguration. The inspectors noted that the temporary procedure had expired and that the guidance was not incorporated into a permanent procedure. The inspectors discussed the issue with licensee staff, who intended to revise the affected procedure to include the instructions.

The second example was failure to have a procedure that provided detailed instructions for ensuring over-pressure of low boiler condensers during a dry cleaning evolution. The licensee indicated that activity would not be performed until the issue regarding compliance with American Society of Mechanical Engineering code requirements was addressed. Since then, the licensee has identified a similar issue regarding the switching of condensers during normal operations and has placed that activity on hold as well.

The inspectors also noted that licensee staff had removed an attachment from the condenser start-up procedure that documented independent verification by operators that specific valves were locked in position to provide the required relief protection. After discussion with the inspectors, the licensee agreed to add the independent verification requirements back to the procedure.

This item will remain open pending resolution of these issues.

6. Exit Meeting Summary

The inspectors presented the inspection results to members of the plant staff and management at the conclusion of the inspection on December 9 and 10, 2004. The plant staff acknowledged the findings presented. The inspectors asked the plant staff whether any materials examined during the inspection should be considered proprietary. No proprietary information was identified.

ATTACHMENT

6. PARTIAL LIST OF PERSONS CONTACTED

*R. O'Kane, Plant Manager
*M. Ginzel, Health Physics Supervisor
D. Mays, Environmental and Regulatory Affairs Manager
B. Vandermeulen, Quality Assurance/Supply Chain Manager

* Denotes those present at the exit meeting on December 10, 2004

7. INSPECTION PROCEDURES USED

IP 88005	Management Organization and Controls
IP 88050	Emergency Preparedness
TI 2600/003	Operational Safety Review

8. ITEMS OPENED, CLOSED, AND DISCUSSED

Item	Status	Description
VIO 40-3392/2004-011-01	Open	Failure to properly perform the UF_6 cylinder pre-filling check.
IFI 40-3392/2003-007-04	Open	Licensee actions to centralize and automate the corrective action system to enhance their ability to perform adverse trend analyses.
VIO 40-3392/2004-008-02	Open	Two examples of conduct of operations that were not specifically addressed or described in detail in written Standard Operating Procedures.

9. LIST OF ACRONYMS USED

ADAMS	Agency Document Access and Management System
CFR	Code of Federal Regulations
CM	Crisis Manager
FMB	Feeds Material Building
IC	Incident Commander
IFI	Inspector Follow-up Item
IP	Inspection Procedure
MOC	Management of Change
NRC	Nuclear Regulatory Commission
PARS	Publicly Available Records
UF_6	Uranium Hexafluoride
VIO	Violation